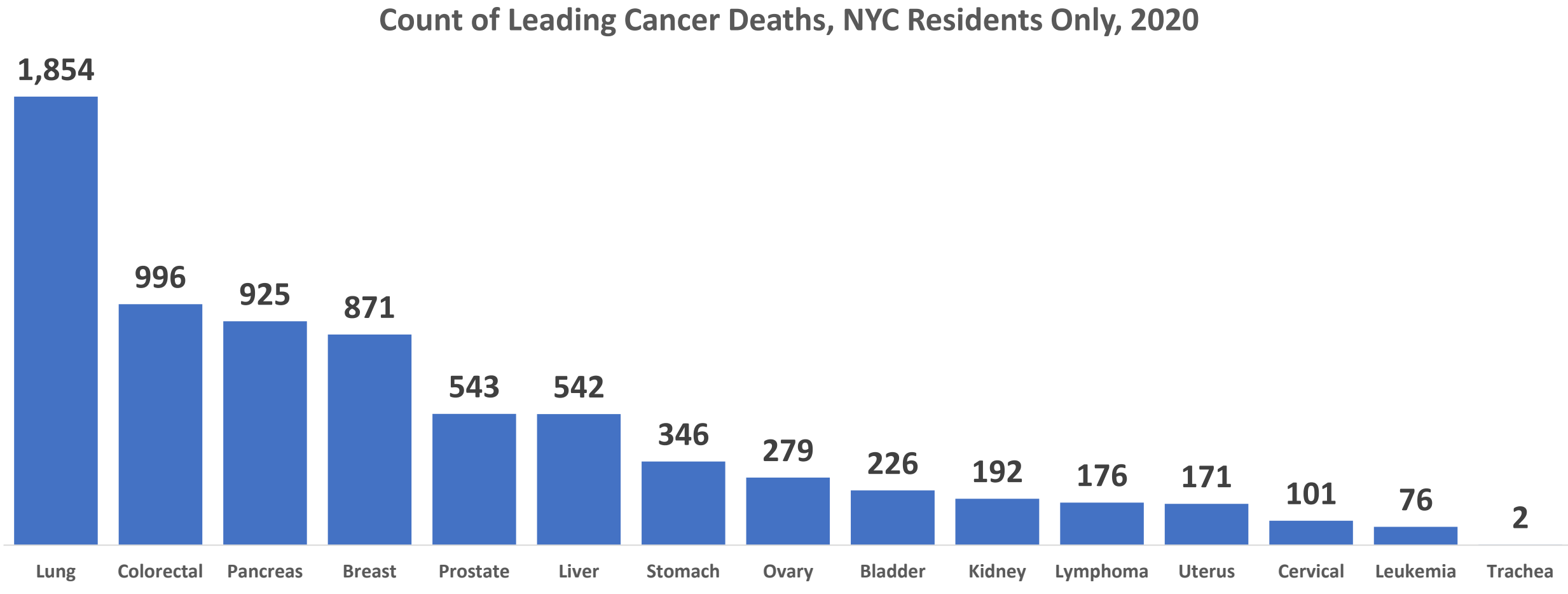
NYC COMMUNITY CARES PROJECT

Project Update as of July 2023

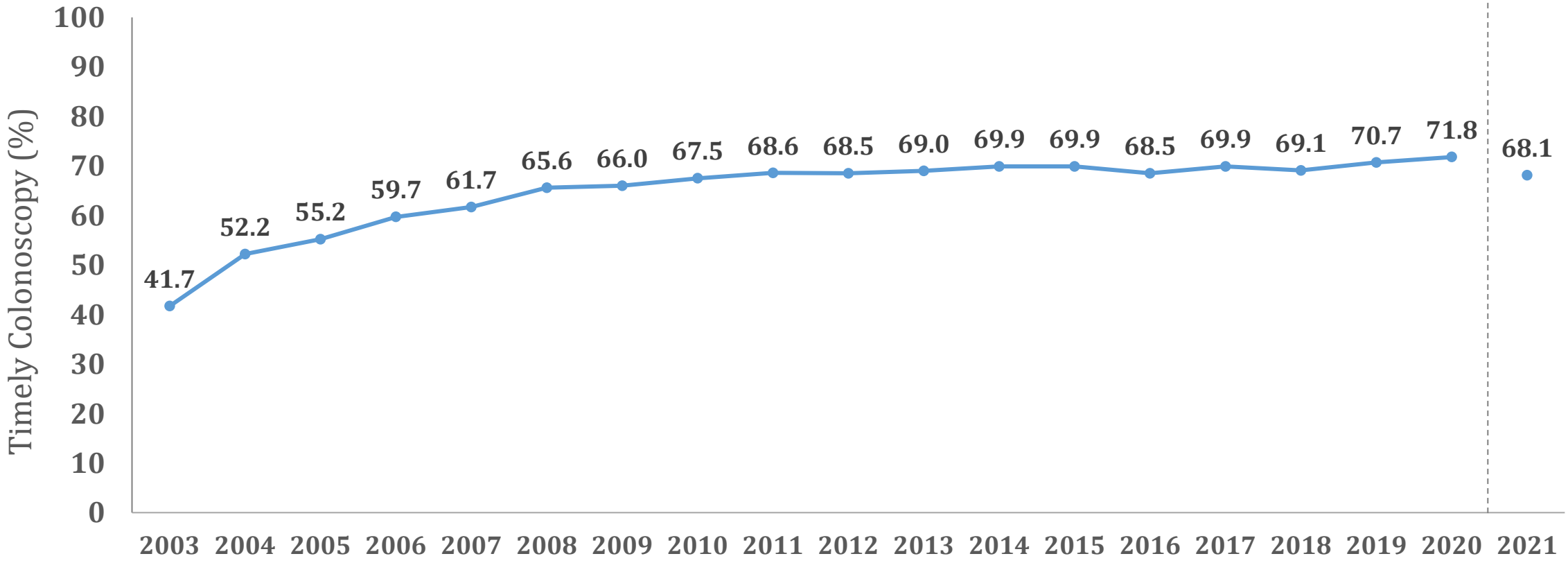
A Leading Cause of Cancer Death in NYC



Source: NYC Office of Vital Statistics, 2020

NYC Health

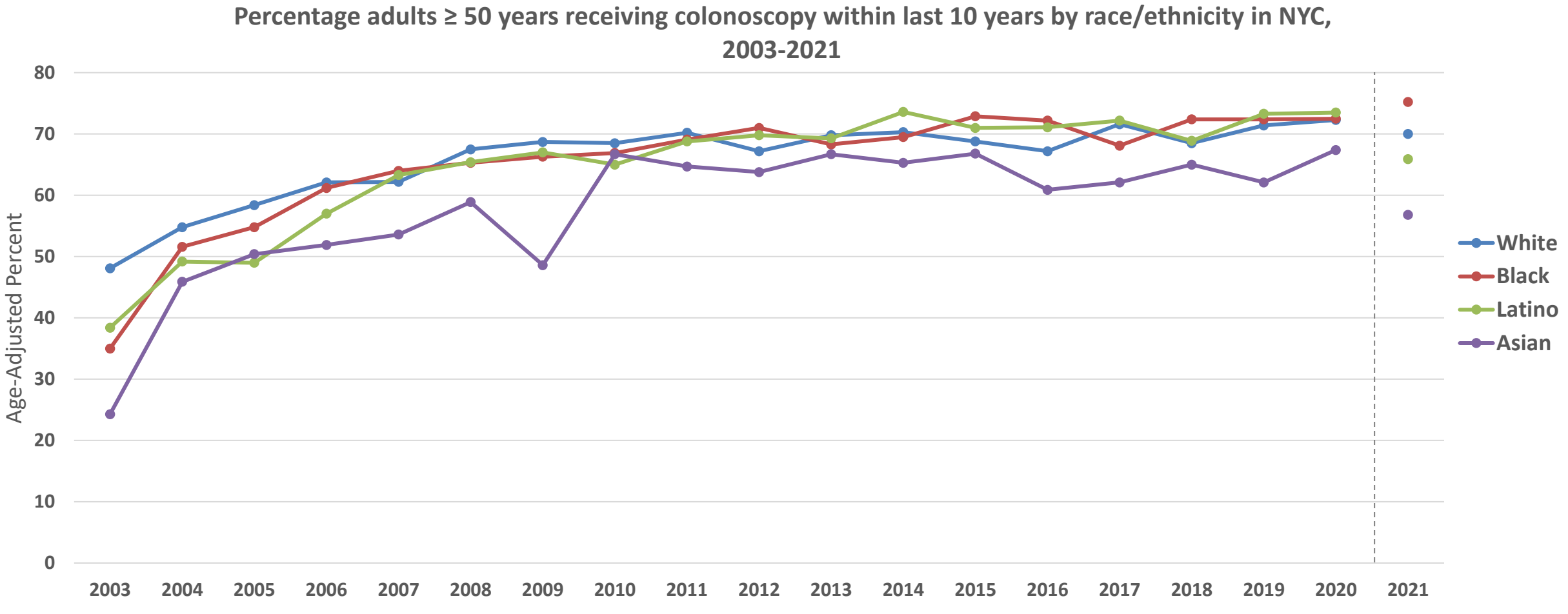
Timely Colonoscopy among NYC Adults Ages 50+ Years, 2003-2021



*Note that the American Cancer Society changed the recommended age for colorectal cancer screenings to 45+

Data Source: NYC Community Health Survey, 2003-2021. CHS has included adults with landline phones since 2002 and, starting in 2009, has also included adults who can be reached by cell phone. In 2021, CHS shifted to Address Based Sample (ABS) in which respondents primarily participate by taking the survey on the web, with phone and paper options also available.
Data are age-adjusted to the US 2000 Standard Population.

Gaps in NYC Screening Colonoscopy Adherence by Race/Ethnicity



Data Source: NYC DOHMH Community Health Survey, 2003-2021. CHS has included adults with landline phones since 2002 and, starting in 2009, has also included adults who can be reached by cell phone. In 2021, CHS shifted to Address Based Sample (ABS) in which respondents primarily participate by taking the survey on the web, with phone and paper options also available.

Trend for each race/ethnicity is significant at $p < .001$.

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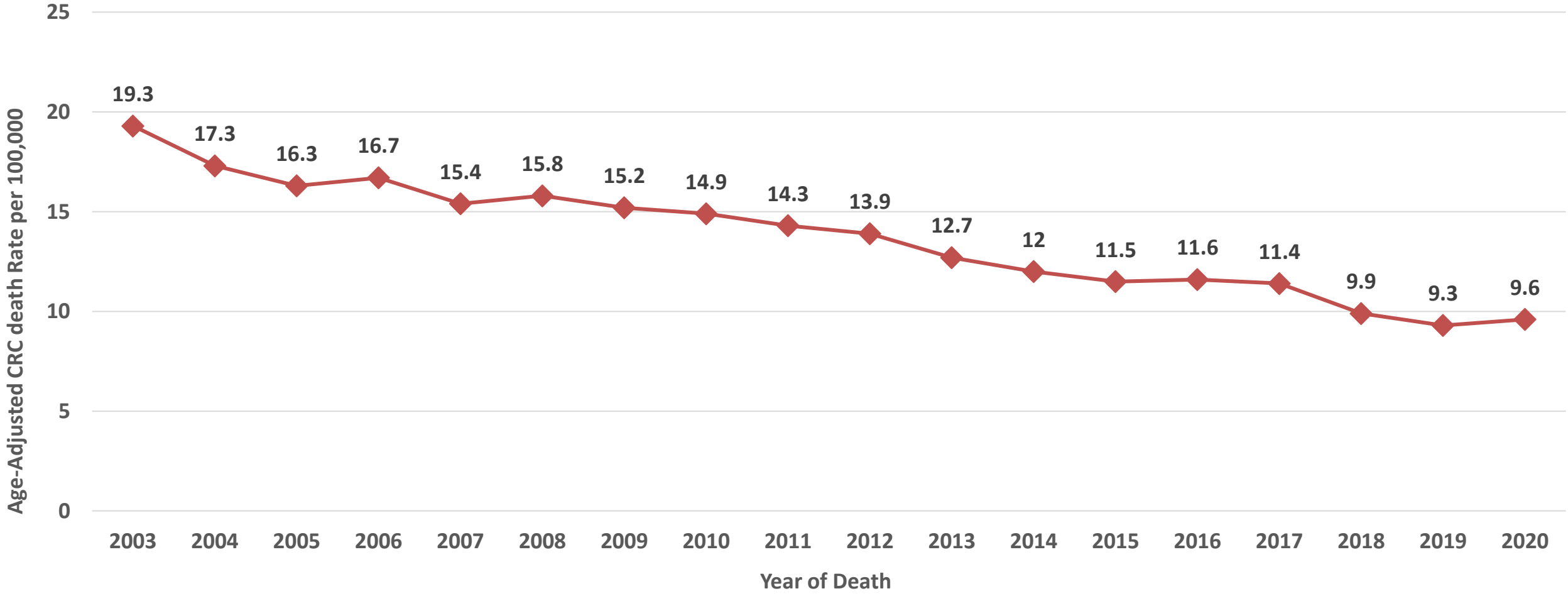
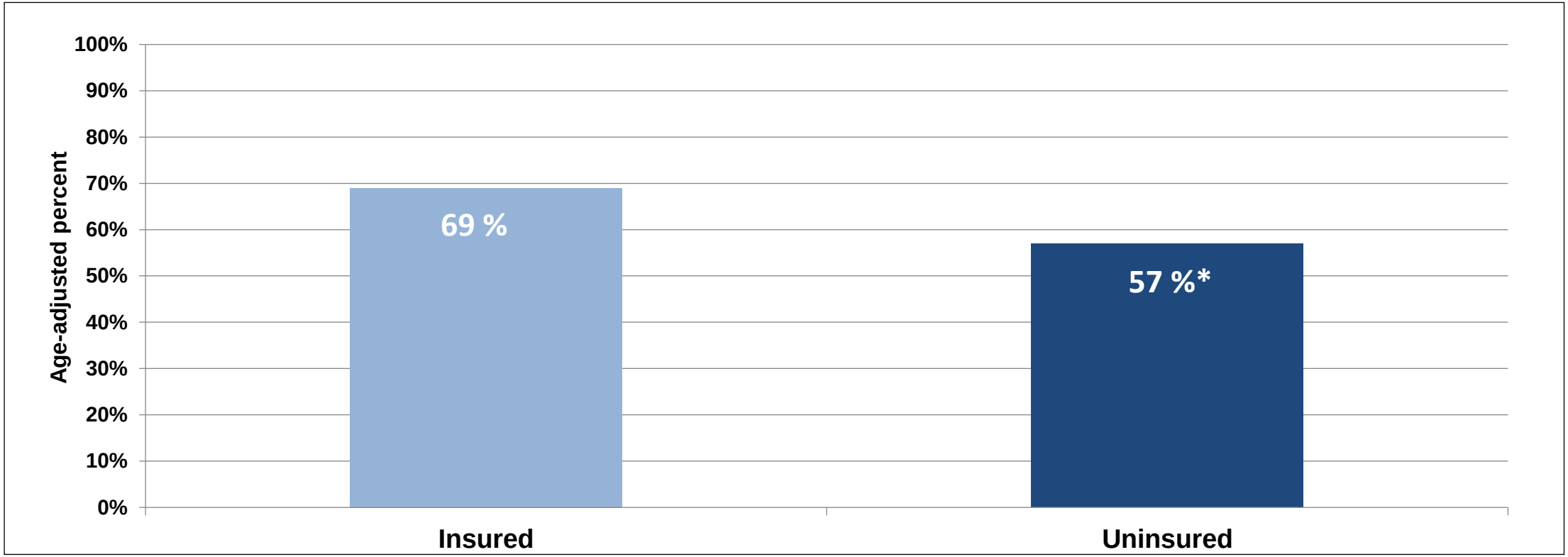
Colorectal Cancer Age-Adjusted Death Rate per 100,000 Population, NYC Residents, 2003 - 2020



Source: NYC Department of Health and Mental Hygiene. Vital Statistics. Death/Mortality Data 2003-2020. Rates are age adjusted to the 2000 US Standard Population (modified from US Census Bureau interpolated intercensal population estimates, 2000-2020)

Colonoscopy Adherence Lower for Uninsured New Yorkers

Percentage NYC adults aged ≥ 50 years receiving colonoscopy in past 10 years, by insurance status, 2021

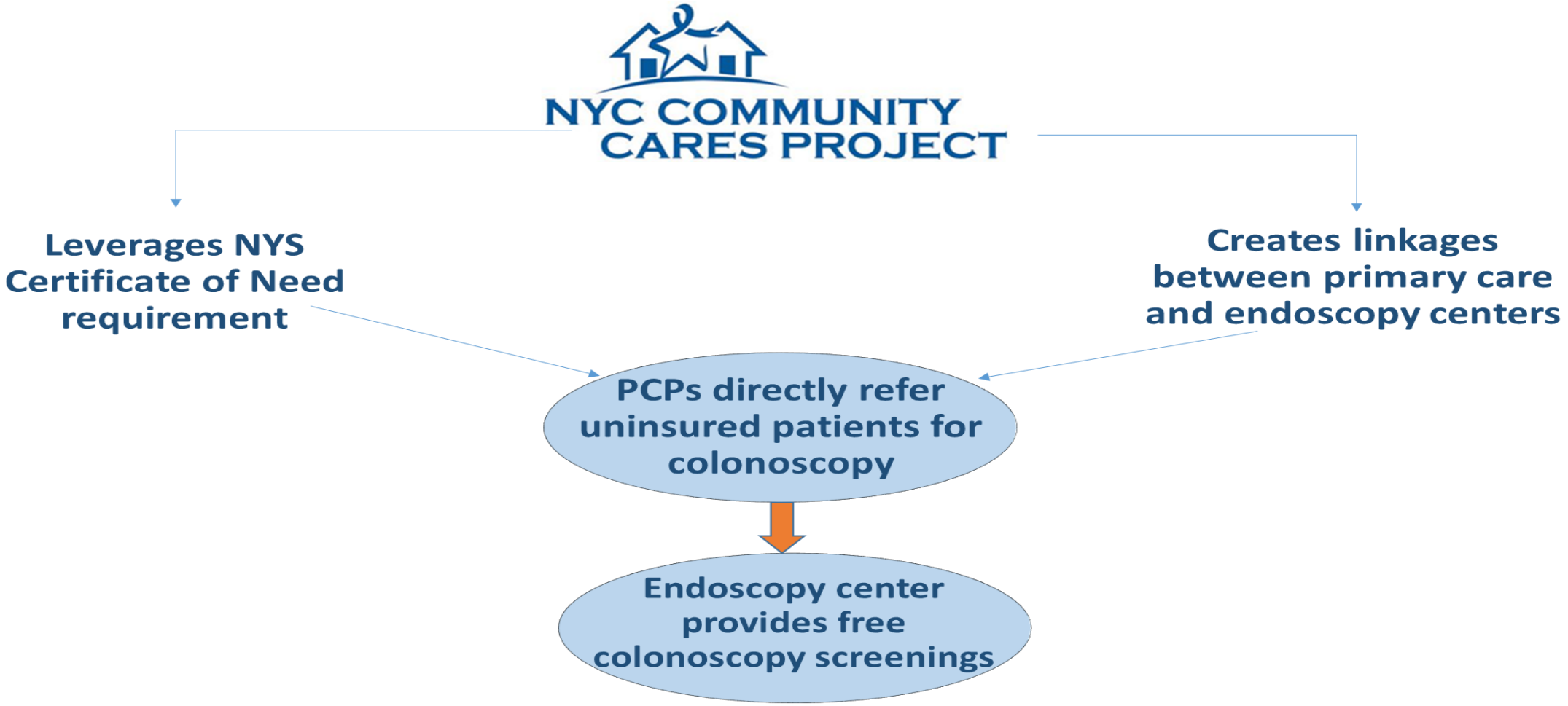


Data Source: NYC DOHMH Community Health Survey, 2021.
*Uninsured estimates are unreliable

Addressing Disparities in Care: Colonoscopy for the Uninsured in NYC

- Interventions are needed to assist uninsured people and those without a PCP
- Community Cares Project (CCP), established in 2013, is a DOHMH intervention
  - Aims to reduce inequity between the insured and uninsured
  - Links uninsured New Yorkers from Community Health Centers to participating Endoscopy Centers
  - They provide colonoscopy, anesthesia and pathology free of charge
- From 2013 to the present day, the total number of patients screened through CCP is 5,180

NYC Community Cares Project (CCP) Model Links Uninsured Patients to Care



The NYC Community Cares Project is a collaboration supported by the C5 Coalition, the NYS Department of Health and the NYC Department of Health and Mental Hygiene.

NYC Health

NYC CCP Referring Primary Care Sites, 2023

Primary Care Networks and Sites

- Charles B. Wang Community Health Center
- Community Healthcare Network
- Family Health Centers at NYU Langone
- Flushing Hospital Medical Center
- Institute for Family Health
- Jamaica Hospital Medical Center
- Ryan Health Network

Health + Hospital Primary Care Sites

- NYC Health + Hospitals/Gotham Health, East New York
- NYC Health + Hospitals/Gotham Health, Gouverneur
- NYC Health + Hospitals/Gotham Health, Morrisania

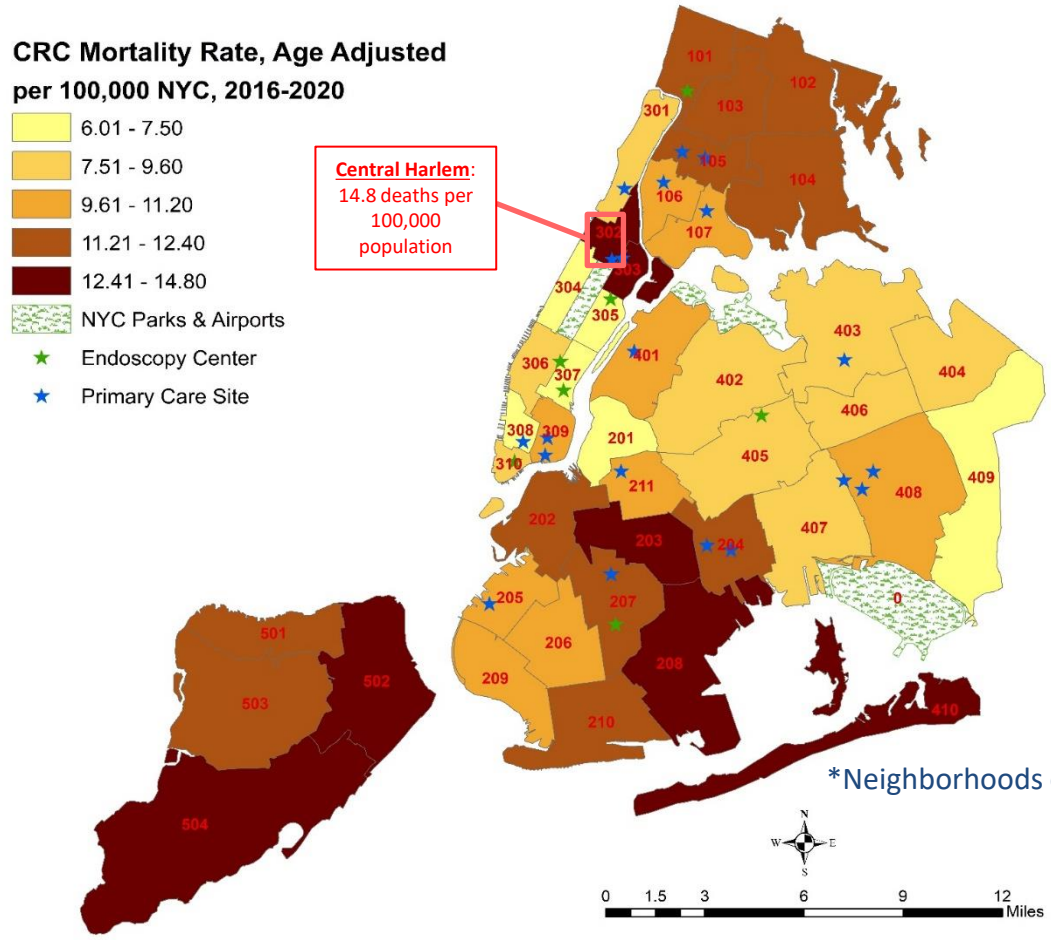
Active participating sites as of July 2023.

NYC CCP Participating Ambulatory Surgery Sites, 2023

- Advanced Endoscopy Center
- Goldstep Ambulatory Surgery Center
- Kips Bay Endoscopy Center
- Liberty Endoscopy Center
- Manhattan Endoscopy Center
- Queens Boulevard Endoscopy Center
- The Endoscopy Center of NY

Active participating sites as of July 2023.

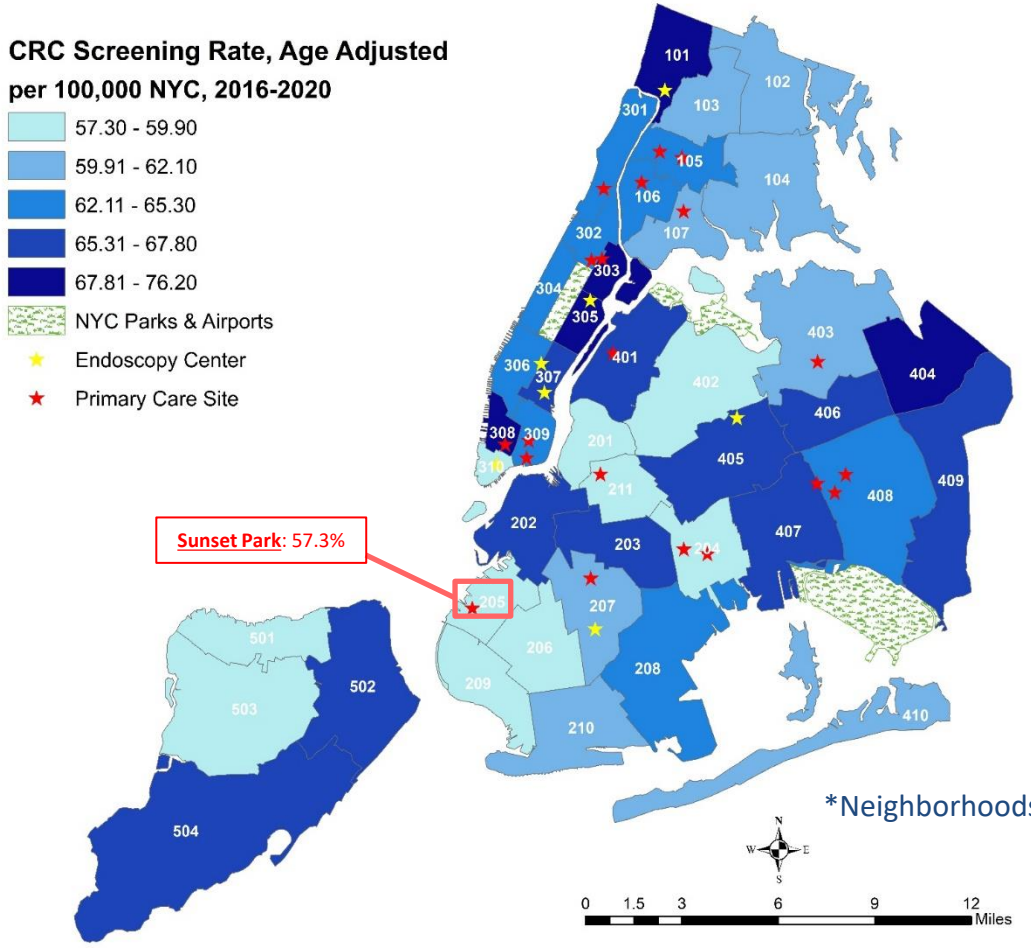
CCP Participating Sites Across the City and Colorectal Cancer Mortality Rates



*Neighborhoods on the map are United Hospital Fund (UHF) Neighborhoods

Source: NYC Department of Health and Mental Hygiene. Vital Statistics. Death/Mortality Data 2016-2020.

CCP Participating Sites Across the City and Colonoscopy Screening Rates



*Neighborhoods on the map are United Hospital Fund (UHF) Neighborhoods

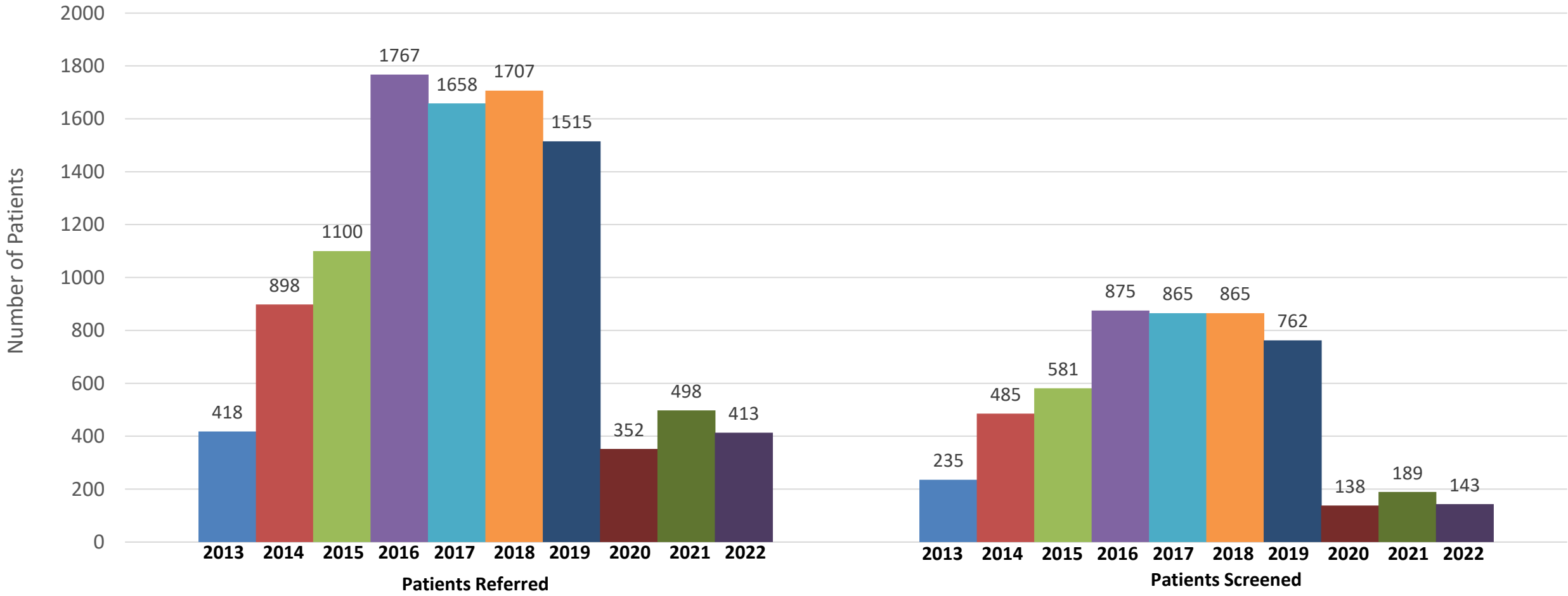
Source: NYC Community Health Survey, 2016-2020. Data are age-adjusted to the US 2000 Standard Population.

NYC CCP Data Collection

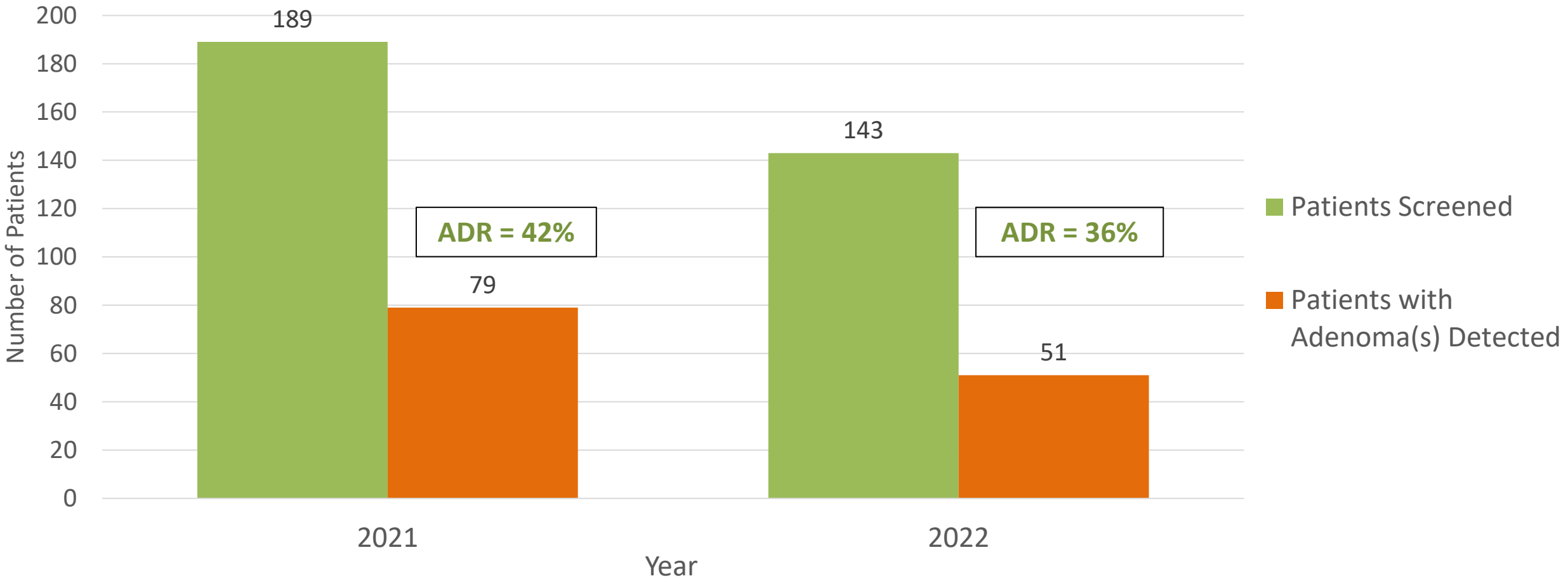
From all participating sites DOHMH collects:

- Number of colonoscopy referrals received from primary care centers
- Number of patients scheduled for colonoscopy
- Number of patients screened by colonoscopy, no-shows, cancellations
- Number of patients with adenomas detected during colonoscopy
- Number of patients with a colon cancer diagnosis

Year over Year Comparison, Uninsured Patients Served 2013 - 2022

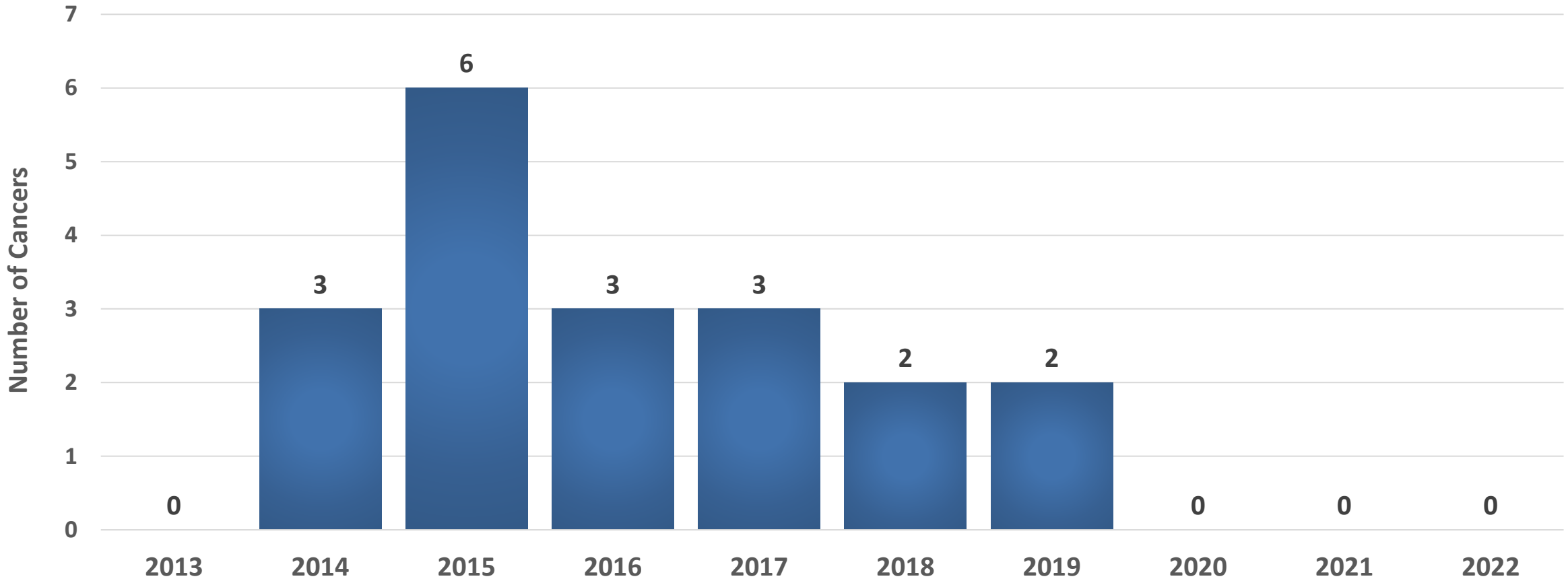


Potential Cancer Prevented Among the Uninsured: CCP Site Adenoma Detection, 2021-2022

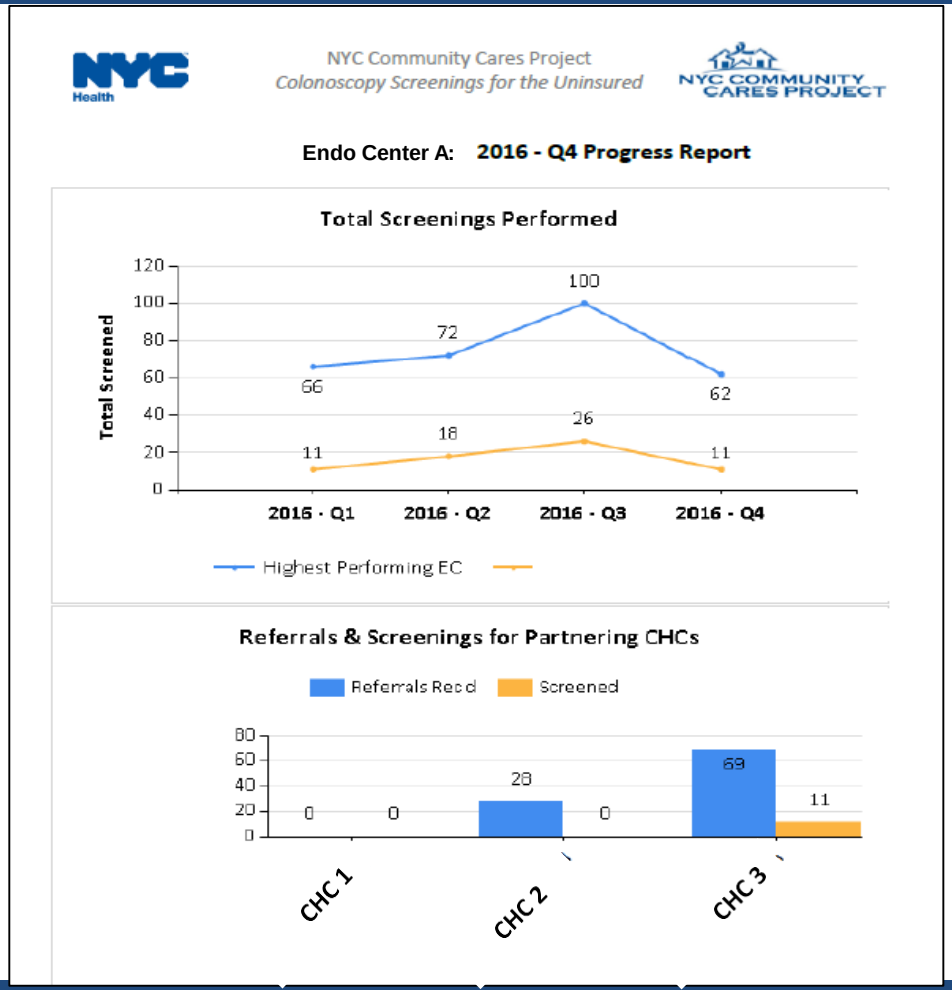


ADR = *Adenoma Detection Rate*, which is the proportion of individuals who had a complete screening colonoscopy and had one or more adenomas divided by the total number of patients screened

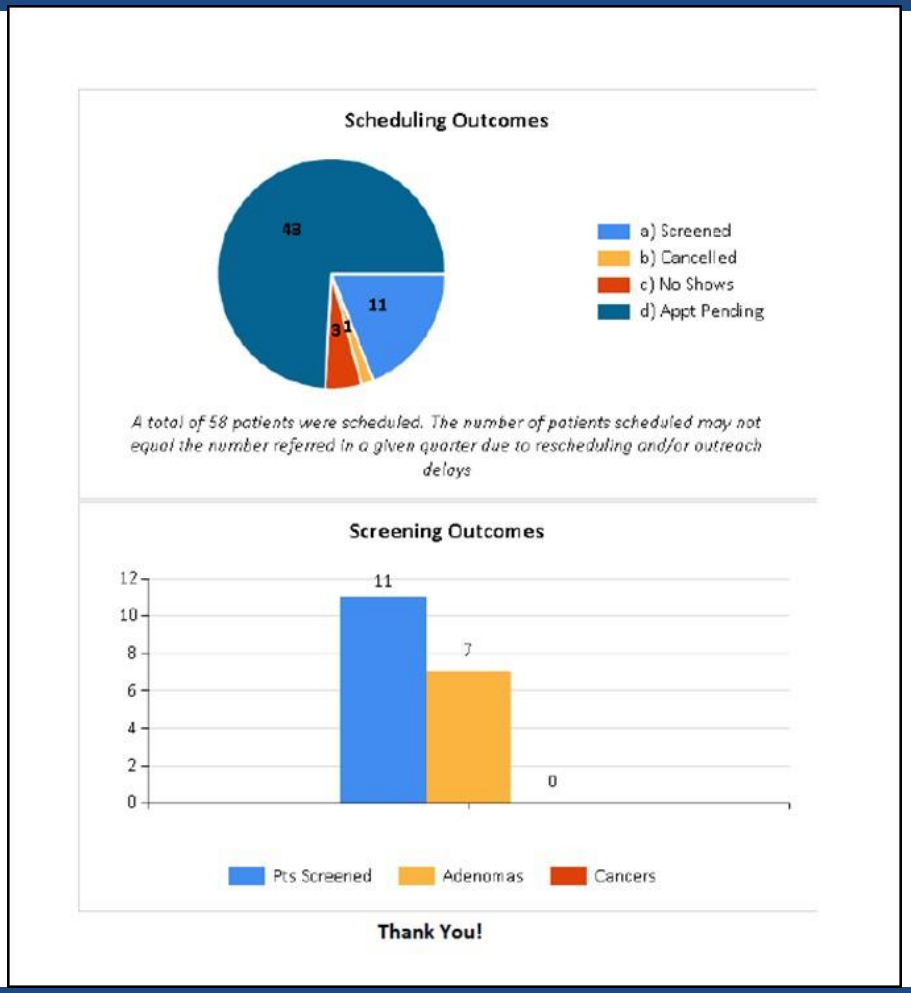
Year over Year comparison, Number of Cancers Detected Among Uninsured Patients Served, 2013-2022



NYC CCP Provides Feedback Reporting to Participating Sites



NYC CCP Feedback Tracks Colonoscopy Completions and Cancer Diagnoses



Providing Different Screening Options to Uninsured Patients Served by CCP's Primary Care Partners

- Benefits of providing screening options to patients
  - May minimize backlog of patients in need of colonoscopy appointments
  - Improves scheduling outcomes (fewer no shows and cancellations reported)
  - Improves CRC screening rates (when considering all options)
- Despite the decline in referrals and screening colonoscopies, some uninsured patients are screened for CRC via stool-based tests
- In the latter half of 2019, CCP started collecting data for stool-based tests

CCP's Stool-based Testing Data from September 2019 to March 2023

Some of CCP's primary care partners regularly submitted stool-based testing data from September 2019 to March 2023

- **15,037** of their uninsured patients received stool-based tests
  - ❖**Over two-thirds** of those who received tests returned them back to centers

Evidence-Based Multicomponent Interventions CCP Uses to Increase Screening

Increase Community Demand

- Group education
- 1 on 1 education
- Client reminders
- **Client Incentives**
- **Mass media**
- **Small media**

Increase Provider Delivery

- Provider reminders
- Provider incentives
- **Provider assessment and feedback**

Source: Community Preventive Services Task Force. The Community Guide, Increasing Cancer Screening: Multicomponent Interventions – Colorectal Cancer. July 2017

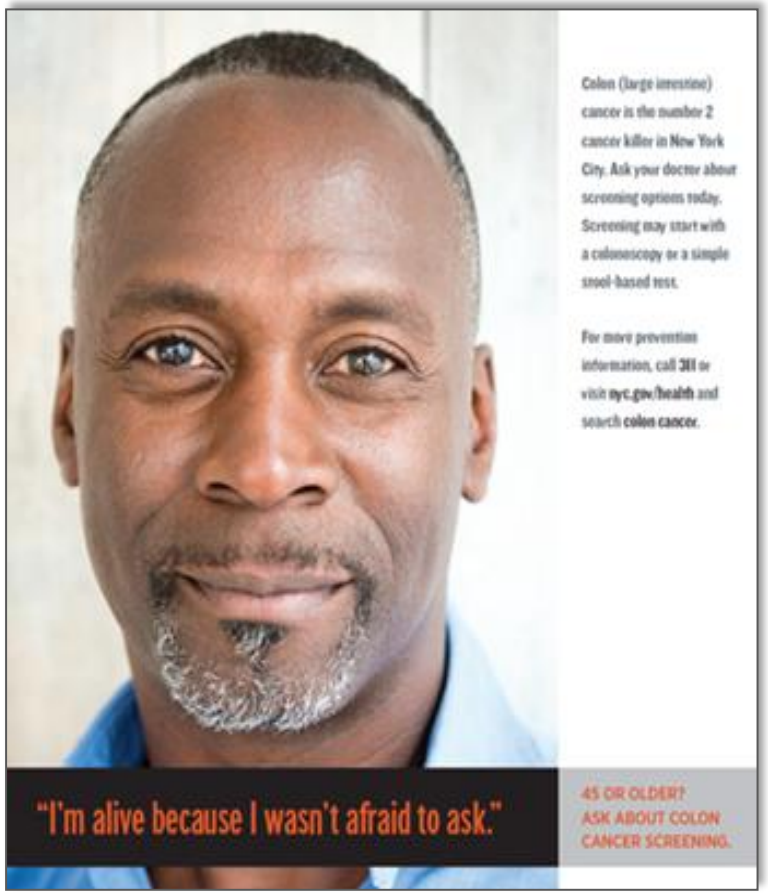
Evidence-Based Multicomponent Interventions CCP Uses to Increase CRC Screening, Cont.

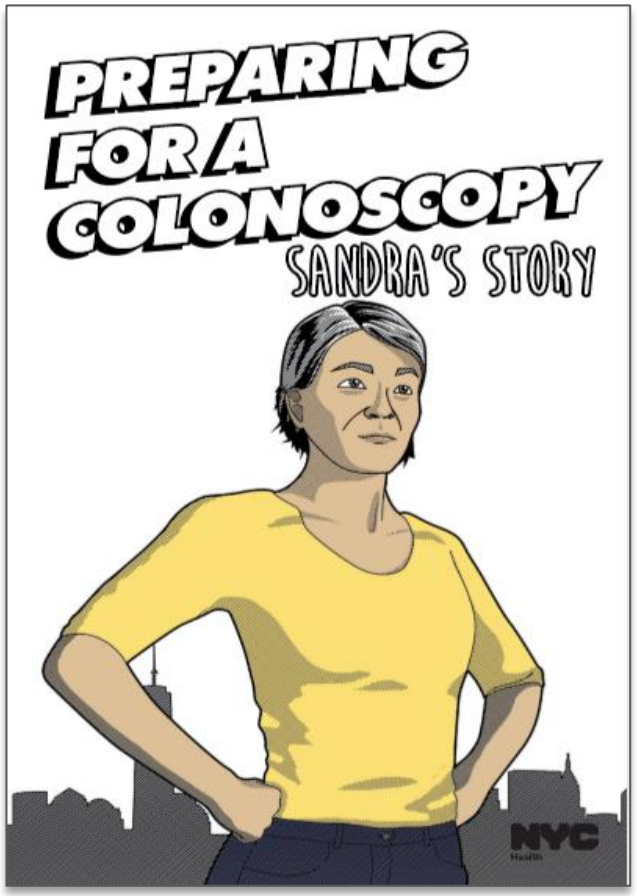
Increase Community Access

- **Interventions to reduce client out of pocket costs**
- **Interventions to reduce structural barriers (ex: patient navigation)**
  - Reducing administrative barriers
  - **Providing appointment scheduling assistance**
  - **Using alternative screening sites**
  - **Alternative screening hours**
  - Providing transportation
  - **Providing translation**
  - Providing childcare

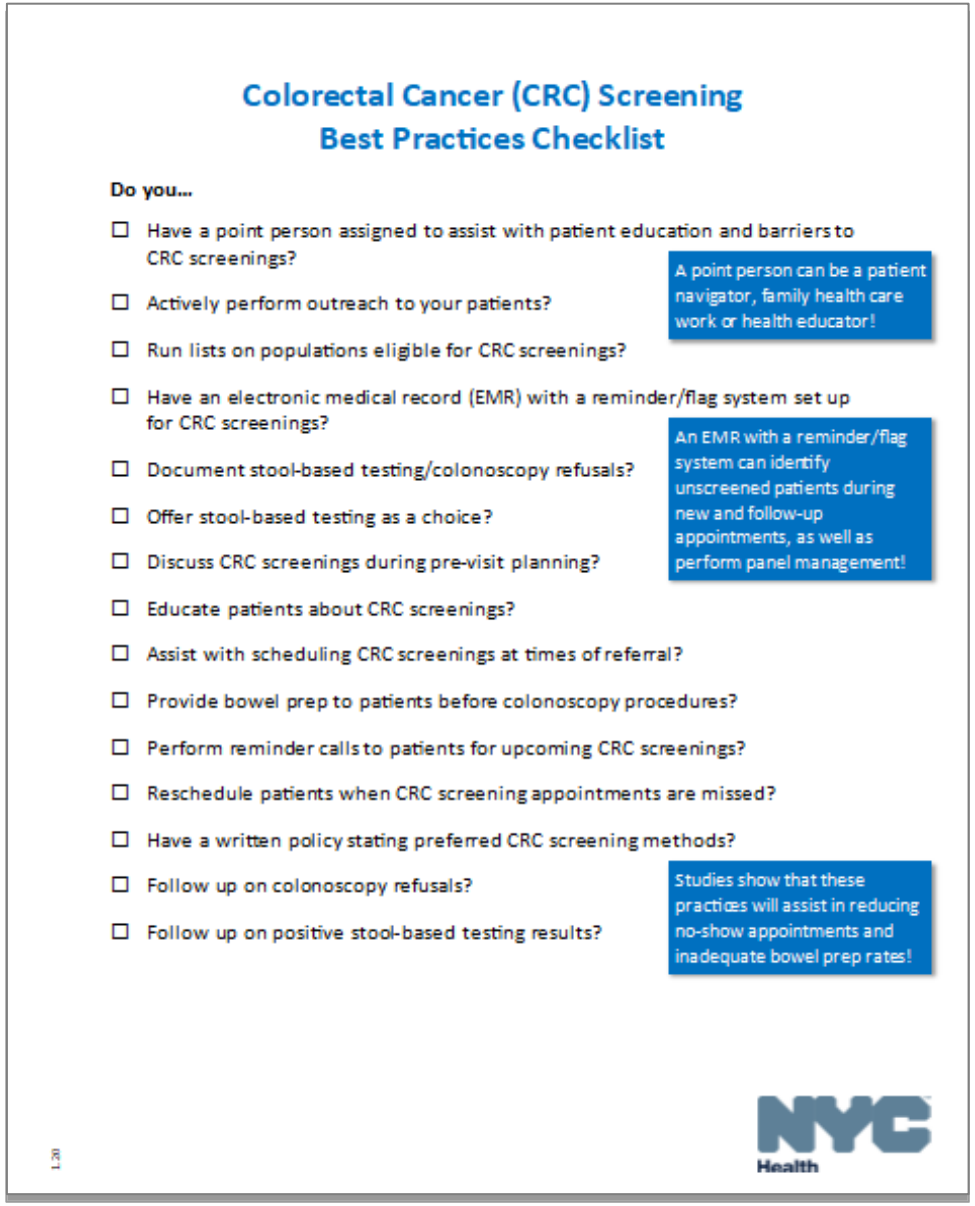
Source: Community Preventive Services Task Force. The Community Guide, Increasing Cancer Screening: Multicomponent Interventions – Colorectal Cancer. July 2017

Examples of Mass Media and Patient Educational Materials Used by DOHMH to Help Increase CRC Screening Rates





CRC Screening Best Practices Checklist



Colorectal Cancer (CRC) Screening Best Practices Checklist

Do you…

- ☐ Have a point person assigned to assist with patient education and barriers to CRC screenings?
- ☐ Actively perform outreach to your patients?
- ☐ Run lists on populations eligible for CRC screenings?
- ☐ Have an electronic medical record (EMR) with a reminder/flag system set up for CRC screenings?
- ☐ Document stool-based testing/colonoscopy refusals?
- ☐ Offer stool-based testing as a choice?
- ☐ Discuss CRC screenings during pre-visit planning?
- ☐ Educate patients about CRC screenings?
- ☐ Assist with scheduling CRC screenings at times of referral?
- ☐ Provide bowel prep to patients before colonoscopy procedures?
- ☐ Perform reminder calls to patients for upcoming CRC screenings?
- ☐ Reschedule patients when CRC screening appointments are missed?
- ☐ Have a written policy stating preferred CRC screening methods?
- ☐ Follow up on colonoscopy refusals?
- ☐ Follow up on positive stool-based testing results?

A point person can be a patient navigator, family health care work or health educator!

An EMR with a reminder/flag system can identify unscreened patients during new and follow-up appointments, as well as perform panel management!

Studies show that these practices will assist in reducing no-show appointments and inadequate bowel prep rates!

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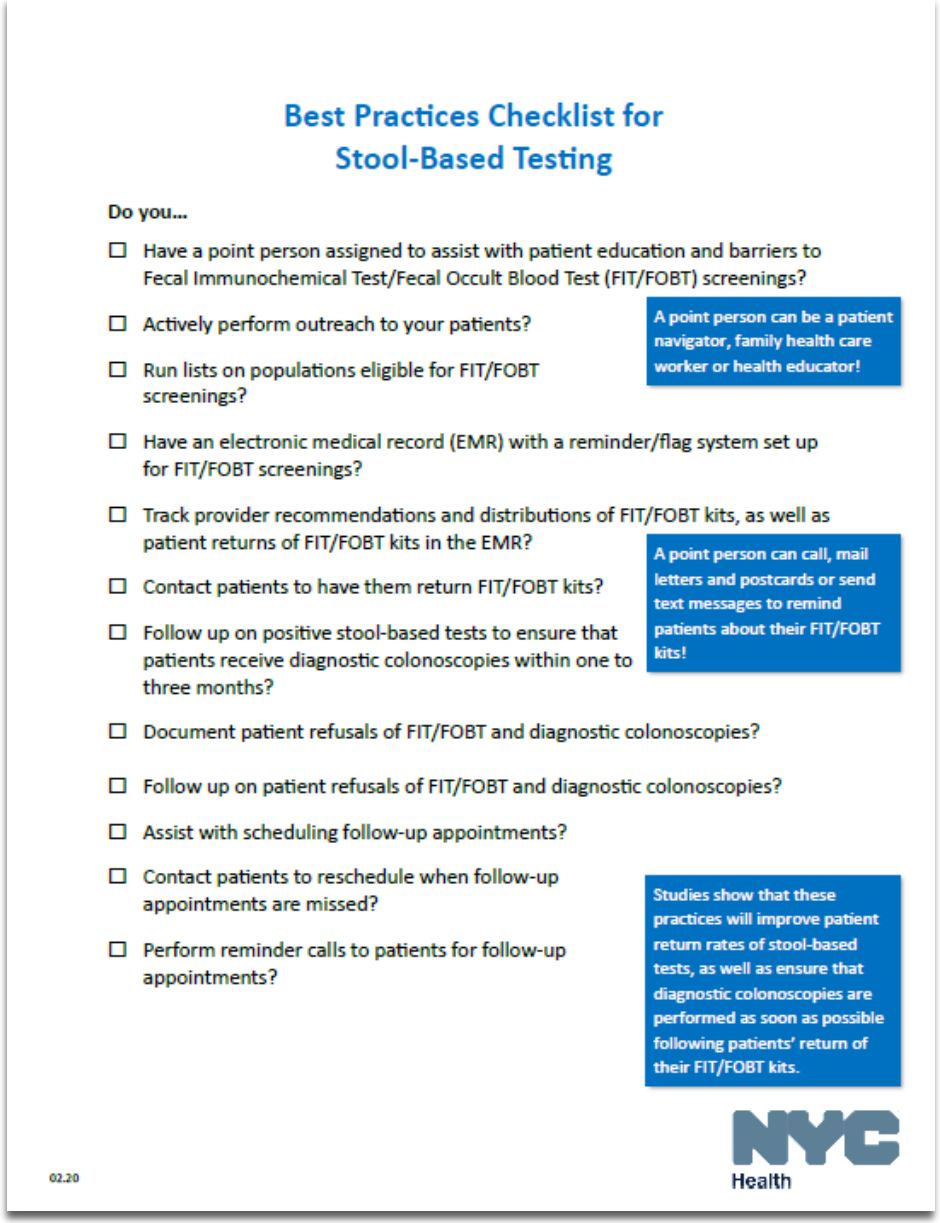
Best Practices Checklist for Stool-Based Testing



Best Practices Checklist for Stool-Based Testing

Do you...

- ☐ Have a point person assigned to assist with patient education and barriers to Fecal Immunochemical Test/Fecal Occult Blood Test (FIT/FOBT) screenings?
- ☐ Actively perform outreach to your patients?
- ☐ Run lists on populations eligible for FIT/FOBT screenings?
- ☐ Have an electronic medical record (EMR) with a reminder/flag system set up for FIT/FOBT screenings?
- ☐ Track provider recommendations and distributions of FIT/FOBT kits, as well as patient returns of FIT/FOBT kits in the EMR?
- ☐ Contact patients to have them return FIT/FOBT kits?
- ☐ Follow up on positive stool-based tests to ensure that patients receive diagnostic colonoscopies within one to three months?
- ☐ Document patient refusals of FIT/FOBT and diagnostic colonoscopies?
- ☐ Follow up on patient refusals of FIT/FOBT and diagnostic colonoscopies?
- ☐ Assist with scheduling follow-up appointments?
- ☐ Contact patients to reschedule when follow-up appointments are missed?
- ☐ Perform reminder calls to patients for follow-up appointments?

A point person can be a patient navigator, family health care worker or health educator!

A point person can call, mail letters and postcards or send text messages to remind patients about their FIT/FOBT kits!

Studies show that these practices will improve patient return rates of stool-based tests, as well as ensure that diagnostic colonoscopies are performed as soon as possible following patients' return of their FIT/FOBT kits.

02.20

NYC Health

Thank You!